TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STEPHEN E. EARLE, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-15-1888-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CODE 22325 WAS DENIED ON THE BASIS BECAUSE 'IT WAS NOT DOCUMENTED.' THAT IS INCORRECT. CODE 22325 REPRESENTS REDUCTION OF SUBLUXATION, INITIAL LEVEL. THIS PROCEDURE IS DOCUMENTED ON PAGE 2 OF THE ATTACHED OPERATIVE REPORT, PARAGRAPH 5, LINES 7-8 'THE PATIENT HAD MANUAL REDUCTION AND SUBLUXATION IN ANATOMIC POSITION IN THE AXIAL, SAGITTAL, AND CORONOAL PLANE AT L4-5…' CODE 22328 WAS DENIED ON THE BASIS BECAUSE 'IT WAS NOT DOCUMENTED.' THAT IS INCORRECT. CODE 22328 REPRESENTS REDUCTION OF SUBLUXATION, ADDITIONAL LEVEL. THIS PROCEDURE IS DOCUMENTED ON PAGE 5 OF THE ATTACHED OPERATIVE REPORT, PRAGRAPH 5, LINES 7-8 'THE PATIENT HAD MANUAL REDUCTION AND SUBLUXATION IN ANATOMIC POSITION IN THE AXIAL, SAGITTAL, AND CORONOAL PLANE AT L5-S1.' CODE 63685 WAS DENIED ON THE BASIS BECAUSE IT WAS NOT DOCUMENTED.' THAT IS INCORRECT. CODE 63685 REPRESENTS USE OF INVASIVE ELECTRICAL STIMULATION. THIS PROCEDURE IS DOCUMENTED ON PAGE 3 OF THE ATTACHED OPERATIVE REPORT, PARAGRAPH 1, LINES 3-4 'THROUGH SEPARATE INCISION OF THE PATIENT'S RIGHT FLANK, THERE WAS IMPLANTATION OF EBI BONE GROWTH STIMULATOR UNIT. CODE 20975 WAS DENIED ON THE BASIS BECAUSE 'IT WAS NOT DOCUMENTED.' THAT IS INCORRECT. CODE 20975 REPRESENTS IMPLANTATION OF BONE GROWTH STIMULATOR. THIS PROCEDURE IS DOCUMENTED ON PAGE 3 OF THE ATTACHED OPERATIVE REPORT, PRAGRAPH 1, LINES 4-5 '…BILATERAL ARTHRODESIS FOR ELECTRICALLY STIMULATING.' CODES 22851 AND 22851-59 WERE DENIED PAYMENT ON THE BASIS OF 'INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.' THAT IS INCORRECT. 22851 REPRESENTS PLACEMENT OF CAGE, A CODE THAT WAS PREAUTHORIZED AS WELL AS DOCUMENTED IN THE ATTACHED OPERATIVE REPORT: PAGE 2, PARAGRAPH 5, LINES 9-10 'THE PATIENT HAD CAGE PLACEMENT AT L4-5, 14 X 22 MM CAGE PLACED THROUGH ELIF APPROACH.' CODE 63030 WAS DENIED ON THE BAIS OF 'INCLUSIVE WITH ANOTHER SERVICE.' THAT IS INCORRECT. PER THE MUTUALLY INCLUSIVE AND EXCLUSIVE TABLE ESTABLISHED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES, CODE 63030 IS NOT INCLUSIVE WITH ANY OTHER CODE REPORTED FOR THIS DATE OF SERVICE. THEREFORE, PAYMENT IS DUE IMMEDIATELY. SINCE PAYMENT IS DUE FOR CODE 63030, PAYMENT IS ALSO DUE FOR CODES 63035-50 AND 63035-59, ADDITIONAL LEVELS OF LAMIENCTOMY AS A SECONDARY PROCEDURE TO 63030, LAMINECTOMY AT THE INITIAL LEVEL."

Amount in Dispute: $14,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Treatment code 20975 was denied because the documented procedure does not appear to match the code description of the code. Additionally, the pain relief code the provider is billing for does not include the bone graft stimulator unit. Treatment Code 22325 was denied because the documentation on the HCFA 1500 form or UB 92 Form is not supported by the medical records provided by the healthcare provider. Treatment Code 22328 was denied because the documentation on the HCFA 1500 form or UB 92 Form is not supported by the medical records provided by the healthcare provider. Treatment Code 22851-

22 was denied because the medical documentation provided does not support the procedure requested. The documentation submitted does not support cage replacement times 4. The documentation only supports one (1) cage per level. Treatment Code 63030 was denied because per AAOS Evidence-Based Clinical Practice Guidelines, this procedure code is included in the surgical code. Because both procedures are performed simultaneously, treatment code 63030 should be bundled and included in 22325. The provider cannot report both codes together in this case. Treatment Codes 63035-50 and 59 were denied because the requested procedure should not be billed without the appropriate primary procedure. Treatment Code 63685 was denied because the requested procedure does not appear to match the code description of the CPT code bill."

Response Submitted by: Smith & Carr, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2014	CPT Code 20975	$500.00	$345.09
	CPT Code 22325	$2,150.00	$1,381.88
	CPT Code 22328	$600.00	$553.41
	CPT Code 22851-59	$1,125.00	$797.13
	CPT Code 22851	$1,125.00	$797.13
	CPT Code 63030-50	$5,000.00	$1,404.28
	CPT Code 63035-50	$1,250.00	$562.99
	CPT Code 63035-59	$1,250.00	$375.33
	CPT Code 63685	$1,000.00	$354.15
TOTAL		$14,000.00	$6,571.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11, 112-Service not furnished directly to the patient and/or not documented.
   - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - P12-Code description not listed.
   - P300-Code description not listed.
   - B12-Services not documented in patients' medical records.
   - 59-Processed based on multiple or concurrent procedure rules.
   - U849-Code description not listed.
   - U058-Code description not listed.
   - B1-Code description not listed.

- 15, 150-Payer deems the information submitted does not support this level of service.
- MZ02-Code description not listed.
- 18-Duplicate claim/service.
- W3-Additional payment made on appeal/reconsideration.
- 193-Code description not listed.

Issues

1. Does the documentation support billing CPT code 20975?
2. Does the documentation support billing CPT codes 22325 and 22328?
3. Does the documentation support billing CPT codes 22851 and 22851-59?
4. Is the allowance of CPT code 63030 included in the allowance of another code rendered on the disputed date?
5. Does the documentation support billing CPT codes 63035-50 and 63035-59?
6. Does the documentation support billing CPT codes 63685-59?
7. What is the total additional reimbursement due the requestor?

Findings

1. The respondent denied reimbursement for CPT code 20975 based upon reason codes "11" and "112." The respondent states in the position summary that "Treatment code 20975 was denied because the documented procedure does not appear to match the code description of the code. Additionally, the pain relief code the provider is billing for does not include the bone graft stimulator unit."

   The requestor argues that reimbursement is due because "CODE 20975 REPRESENTS IMPLANTATION OF BONE GROWTH STIMULATOR. THIS PROCEDURE IS DOCUMENTED ON PAGE 3 OF THE ATTACHED OPERATIVE REPORT, PRAGRAPH 1, LINES 4-5 '…BILATERAL ARTHRODESIS FOR ELECTRICALLY STIMULATING.'"

   28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 20975 is defined as "Electrical stimulation to aid bone healing; invasive (operative)."

   A review of the submitted Operative Report finds that the requestor documented procedure; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203.

2. Reimbursement for codes 22325 and 22328 were denied based upon reason code "B12." The respondent states "Treatment Code 22325 was denied because the documentation on the HCFA 1500 form or UB 92 Form is not supported by the medical records provided by the healthcare provider. Treatment Code 22328 was denied because the documentation on the HCFA 1500 form or UB 92 Form is not supported by the medical records provided by the healthcare provider."

   CPT code 22325 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar."

   The requestor indicated that "CODE 22325 REPRESENTS REDUCTION OF SUBLUXATION, INITIAL LEVEL. THIS PROCEDURE IS DOCUMENTED ON PAGE 2 OF THE ATTACHED OPERATIVE REPORT, PARAGRAPH 5, LINES 7-8 'THE PATIENT HAD MANUAL REDUCTION AND SUBLUXATION IN ANATOMIC POSITION IN THE AXIAL, SAGITTAL, AND CORONOAL PLANE AT L4-5…' CODE 22328 REPRESENTS REDUCTION OF SUBLUXATION, ADDITIONAL LEVEL. THIS PROCEDURE IS DOCUMENTED ON PAGE 5 OF THE ATTACHED OPERATIVE REPORT, PRAGRAPH 5, LINES 7-8 'THE PATIENT HAD MANUAL REDUCTIONA AND SUBLUXATION IN ANATOMIC POSITION IN THE AXIAL, SAGITTAL, AND CORONOAL PLANE AT L5-S1.'"

   A review of the Operative Report finds that the requestor documented procedure; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203.

3. On the disputed date of service, the requestor billed CPT code 22851 and 22851-59. CPT code 22851 is defined as "Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)." The requestor noted on the Table of Disputed Services 22851-22; however a review of the bill indicates the modifier is "59-Distinct Procedural Service" to the second unit of 22851.

The respondent contends that payment "was denied because the medical documentation provided does not support the procedure requested. The documentation submitted does not support cage replacement times 4. The documentation only supports one (1) cage per level."

The requestor states that "22851 REPRESENTS PLACEMENT OF CAGE, A CODE THAT WAS PREAUTHORIZED AS WELL AS DOCUMENTED IN THE ATTACHED OPERATIVE REPORT: PAGE 2, PARAGRAPH 5, LINES 9-10 'THE PATIENT HAD CAGE PLACEMENT AT L4-5, 14 X 22 MM CAGE PLACED THROUGH ELIF APPROACH.'"

CPT code 22851 is reimbursable for each interspace treated. A review of the Operative Report finds that the requestor documented cage placement at L4-5 and L5-S1; therefore, reimbursement for code 22851 and 22851-59 is recommended per 28 Texas Administrative Code §134.203.

4. According to the explanation of the respondent denied reimbursement for CPT code 63030-50 based upon reason code "97." The respondent contends that reimbursement is not due based upon "Treatment Code 63030 was denied because per AAOS Evidence-Based Clinical Practice Guidelines, this procedure code is included in the surgical code. Because both procedures are performed simultaneously, treatment code 63030 should be bundled and included in 22325."

   On the disputed date of service, the requestor billed codes 63030-50, 63035-50, 63011-59-22, 62290, 20938, 20930, 20926, 22325-59, 22328, 22533, 22534, 22612, 22614, 22851, 22851-59, 22842-59, 20975-59, 63685-59, 63035-59, 62290-59, 22851-22 and 22851-99.

   CPT code 63030 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar." A review of the submitted medical bill finds that the requestor appended modifier "50-Bilateral Procedures" to code 63030.

   28 Texas Administrative Code §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Per CCI edits, CPT code 63030-50 is not a component of any other procedure/service rendered on the disputed date; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203.

5. Per the explanation of benefits, the respondent denied reimbursement for CPT codes 63035-50 and 63035-59 based upon reason code "16." The respondent maintains the denial based upon, "Treatment Codes 63035-50 and 59 were denied because the requested procedure should not be billed without the appropriate primary procedure."

   The requestor states "SINCE PAYMENT IS DUE FOR CODE 63030, PAYMENT IS ALSO DUE FOR CODES 63035-50 AND 63035-59, ADDITIONAL LEVELS OF LAMIENCTOMY AS A SECONDARY PROCEDURE TO 63030, LAMINECTMY AT THE INITIAL LEVEL."

   CPT code 63035 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)." The requestor appended modifiers "50-Bilateral Procedures" and "59-Distinct Procedural Service" to code 63035.

   The Operative Report indicates decompression was performed bilaterally to interspaces L3-4, L4-5 and L5-S1; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203.

6. CPT code 63685 is defined as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling." The requestor appended modifier "59-Distinct Procedural Service" to code 63685.

   Modifier 59-Distinct Procedural Service is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   The respondent contends that "Treatment Code 63685 was denied because the requested procedure does not appear to match the code description of the CPT code bill."

In regards to code 63685-59, the requestor states "CODE 63685 REPRESENTS USE OF INVASIVE ELECTRICAL STIMULATION. THIS PROCEDURE IS DOCUMENTED ON PAGE 3 OF THE ATTACHED OPERATIVE REPORT, PARAGRAPH 1, LINES 3-4 'THROUGH SEPARATE INCISION OF THE PATIENT'S RIGHT FLANK, THERE WAS IMPLANTATION OF EBI BONE GROWTH STIMULATOR UNIT."

A review of the Operative Report supports billing code 63685; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203.

7. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2014 DWC conversion factor for this service is 69.98.

   The Medicare Conversion Factor is 35.8228

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78233, which is located in Live Oak; therefore, the Medicare participating amount is based on locality "Rest of Texas".

   Per Medicare's multiple surgery pricing the allowance is calculated at 100% for the principal procedure and 50% of the secondary procedures that are subject to multiple surgery pricing. A review of the submitted explanation of benefits, finds that the respondent paid the requestor at 100% for code 22533; therefore, the 50% reduction will be taken to the remaining procedures that are subject to the multiple procedure reduction.

   Per Medicare's Surgery Guidelines, bilateral procedures are billed with modifier "50" and the allowance is calculated by multiplying the fee schedule by 150%.

   Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement (MAR)	Total Insurance Carrier Paid	Total Amount Due
20975	$176.65	$345.09	$0.00	$345.09
22325	$1,414.77	$2,763.76 X 50% = $1,381.88	$0.00	$1,381.88
22328	$283.29	$553.41	$0.00	$553.41
22851-59	$408.05	$797.13	$0.00	$797.13
22851	$408.05	$797.13	$0.00	$797.13
63030-50	$958.47	$1,872.38 x 50% = $936.19 X 150% = $1,404.28	$0.00	$1,404.28
63035-50	$192.13	$375.33 x 150% = $562.99	$0.00	$562.99

63035-59	$192.13	$375.33	$0.00	$375.33
63685	$362.58	$708.30 x 50% = $354.15	$0.00	$354.15
TOTAL				$6,571.39

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,571.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,571.39 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		08/26/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.